Cosmetic Surgery CENTER

Acct. # _____

New Patient Information (Please Print) **ALLERGIES_____** **Appt. Date:**

NAME	DOB / AGE	GENDER M / F	SOCIAL SECURITY #	MARITAL STATUS S M D W SEP
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE # with area code	
EMPLOYER			BUSINESS PHONE # with area code	
OCCUPATION			CELL PHONE # with area code	
SPOUSE / SIGNIFICANT OTHER	SPOUSE / SIGNIFICANT OTHER'S EMPLOYER / OCCUPATION		BUSINESS PHONE #	
EMERGENCY CONTACT (ALSO, MAY WE CONTACT THIS PERSON IF YOU CANNOT BE REACH?) **YES / NO**				
STREET ADDRESS	CITY, STATE AND ZIP	CELL PHONE #	WORK PHONE #	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY DR. BRANMAN?			YES	NO
REFERRAL SOURCE (PLEASE FILL IN)	SEND THANK YOU?	STREET ADDRESS, CITY, STATE, & ZIP		

Email address: _____

Reason for consultation: _____

Patient's or authorized person's signature is required. (Please read and sign.)

Are you on Medicaid and/or Medicare? Please circle YES / NO

(If yes, you will need to sign a copy of the Medicaid/Medicare Waiver Form.)

****Dr. Branman does not participate with any insurances including Medicare/Medicaid.****

All professional services rendered are charged to the patient. The patient or patient's guardian is responsible for all fees. It is customary to pay for surgical and *select* procedures in advance and other services when rendered unless other arrangements have been made in advance. I agree that I will not record, in any way, anything, which occurs in the office of Dr. Branman without prior written consent by him. A doctor-patient relationship is a consensual agreed upon contractual relationship between Dr. Branman and me. Either party can agree or disagree to enter into a doctor-patient relationship. I agree that no doctor-patient relationship will be established between Dr. Branman and me until Dr. Branman has administered a definite treatment procedure to me. I agree a definite treatment procedure by definition is limited to: therapeutic injections, chemical peels, laser treatments, or direct surgical intervention. I further agree that my office consultation, surgical fee deposit, or scheduling of surgery does not constitute a definite treatment procedure or a doctor patient relationship. I understand it is my responsibility to **be reached by Dr. Branman and his staff when I have an upcoming surgery or procedure. I agree that Dr. Branman may cancel at will any office or surgical appointment without notice or cause.**

Signature_____ **Date_____**

We request our patients update their information ANNUALLY. Please review your forms, then date and initial.

Reviewed and Updated on: _____ Patient Initials_____